



PATIENT GRIEVANCE FORM

All information will be kept confidential. Complete all blanks that relate to your concern.
Return form to The Renal Network (see address below).

Patient Information:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: () _____ Cell Phone: () _____

Facility/Unit Associated with the Grievance:

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: () _____ Cell Phone: () _____

Grievance Involves: *(Check all specifically involved)*

Facility/Unit Staff:

Name: _____ Title: _____

Name: _____ Title: _____

Physician(s):

Name: _____ Title: _____

Name: _____ Title: _____

Other *(specify)*

*The Renal Network – 911 East 86th Street Suite 202 – Indianapolis, IN 46240
Phone: 317-257-8265 – Patient Line: 800-456-6919 – Fax: 317-257-8291
E-Mail: kstark@nw10.esrd.net*

Please check the ONE that applies to you:

- I have approached the facility with this grievance and am not satisfied with the outcome or handling. I am not satisfied because: *(specify reason)*

- I have not approached the facility with this grievance because: *(specify reason)*

Please check ONE:

- I choose to represent myself during this grievance process.
- I am the legal guardian for the patient. (Attach guardianship papers)
- I have chosen the following representative to help me during this grievance process

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Daytime Phone: () _____ Cell Phone: () _____

Please check ONE:

- I allow the Network to release my identity to the appropriate individuals in the processing of this grievance.
- I wish to remain anonymous. I understand that remaining anonymous may result in the inability to fully process my grievance and if this is the case, the Network will notify me.

_____/_____/_____
Signature of Person Filing Grievance

_____/_____/_____
Signature of Patient or Guardian (if applicable)

_____/_____/_____
Signature of Patient Representative (if applicable)

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